Name: _____ DOB:_____ Date: _____

60 Months (57 Months 0 days through 66 months 0 days)

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Without your giving help by pointing or repeating directions, does your child follow three directions that are *unrelated* to one another? Give all three directions before your child starts. For example, you may ask your child, "Clap your hands, walk to the door, and sit down," or "Give me the pen, open the book, and stand up."	○	○	○	___
2. Does your child use four- and five-word sentences? For example, does your child say, "I want the car"? Please write an example:	○	○	○	___
3. When talking about something that already happened, does your child use words that end in "-ed," such as "walk*ed*," "jump*ed*," or "play*ed*"? Ask your child questions, such as "How did you get to the store?" ("We walk*ed*.") "What did you do at your friend's house?" ("We play*ed*.") Please write an example:	○	○	○	___
4. Does your child use comparison words, such as "heavier," "stronger," or "shorter"? Ask your child questions, such as "A car is big, but a bus is _____" (bigger); "A cat is heavy, but a man is _____" (heavier); "A TV is small, but a book is _____" (smaller). Please write an example:	○	○	○	___
5. Does your child answer the following questions? *(Mark "sometimes" if your child answers only one question.)* "What do you do when you are hungry?" *(Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.")* Please write your child's response:	○	○	○	___
"What do you do when you are tired?" *(Acceptable answers include: "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.")* Please write your child's response:				
6. Does your child repeat the sentences shown below back to you, without any mistakes? *(Read the sentences one at a time. You may repeat each sentence one time. Mark "yes" if your child repeats both sentences without mistakes or "sometimes" if your child repeats one sentence without mistakes.)* Jane hides her shoes for Maria to find. Al read the blue book under his bed.	○	○	○	___

COMMUNICATION TOTAL ____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While standing, does your child throw a ball *overhand* in the direction of a person standing at least 6 feet away? To throw overhand, your child must raise his arm to shoulder height and throw the ball forward. *(Dropping the ball or throwing the ball underhand should be scored as "not yet.")*	○	○	○	___
2. Does your child catch a large ball with both hands? *(You should stand about 5 feet away and give your child two or three tries before you mark the answer.)*	○	○	○	___
3. Without holding onto anything, does your child stand on one foot for at least 5 seconds without losing her balance and putting her foot down? *(You may give your child two or three tries before you mark the answer.)*	○	○	○	___
4. Does your child walk on his tiptoes for 15 feet (about the length of a large car)? *(You may show him how to do this.)*	○	○	○	___
5. Does your child hop forward on one foot for a distance of 4–6 feet without putting down the other foot? *(You may give her two tries on each foot. Mark "sometimes" if she can hop on one foot only.)*	○	○	○	___
6. Does your child skip using alternating feet? *(You may show him how to do this.)*	○	○	○	___

GROSS MOTOR TOTAL ____

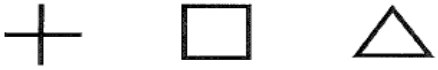
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Ask your child to trace on the line below with a pencil. Does your child trace on the line without going off the line more than two times? *(Mark "sometimes" if your child goes off the line three times.)*	○	○	○	___

2. Ask your child to draw a picture of a person on a blank sheet of paper. You may ask your child, "Draw a picture of a girl or a boy." If your child draws a person with head, body, arms, *and* legs, mark "yes." If your child draws a person with only three parts (head, body, arms, or legs), mark "sometimes." If your child draws a person with two or fewer parts (head, body, arms, or legs), mark "not yet." Be sure to include the sheet of paper with your child's drawing with this questionnaire. ○ ○ ○ ___

3. Draw a line across a piece of paper. Using child-safe scissors, does your child cut the paper in half on a more or less straight line, making the blades go up and down? *(Carefully watch your child's use of scissors for safety reasons.)* ○ ○ ○ ___

4. Using the shapes below to look at, does your child copy the shapes in the space below without tracing? *(Your child's drawings should look similar to the design of the shapes below, but they may be different in size. Mark "yes" if she copies all three shapes; mark "sometimes" if your child copies two shapes.)* ○ ○ ○ ___



(Space for child's shapes)

Name: _____ DOB:_____ Date: _____

60 Months (57 Months 0 days through 66 months 0 days)

FINE MOTOR

YES SOMETIMES NOT YET

5. Using the letters below to look at, does your child copy the letters without tracing? Cover up all of the letters except the letter being copied. *(Mark "yes" if your child copies four of the letters and you can read them. Mark "sometimes" if your child copies two or three letters and you can read them.)* ○ ○ ○ ___

V H T C A

(Space for child's letters)

6. Print your child's first name. Can your child copy the letters? The letters may be large, backward, or reversed. *(Mark "sometimes" if your child copies about half of the letters.)* ○ ○ ○ ___

(Space for adult's printing)

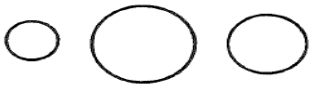
(Space for child's printing)

FINE MOTOR TOTAL ___

PROBLEM SOLVING

YES SOMETIMES NOT YET

1. When asked, "Which circle is smallest?" does your child point to the smallest circle? *(Ask this question without providing help by pointing, gesturing, or looking at the smallest circle.)* ○ ○ ○ ___



2. When shown objects and asked, "What color is this?" does your child name five different colors like red, blue, yellow, orange, black, white, or pink? *(Mark "yes" only if your child answers the question correctly using five colors.)* ○ ○ ○ ___

3. Does your child count up to 15 without making mistakes? If so, mark "yes." If your child counts to 12 without making mistakes, mark "sometimes." ○ ○ ○ ___

4. Does your child finish the following sentences using a word that means the opposite of the word that is italicized? For example: "A rock is *hard*, and a pillow is *soft*." ○ ○ ○ ___

Please write your child's responses below:

A cow is *big*, and a mouse is _____

Ice is *cold*, and fire is _____

We see stars at *night*, and we see the sun during the _____

When I throw the ball *up*, it comes _____

(Mark "yes" if he finishes three of four sentences correctly. Mark "sometimes" if he finishes two of four sentences correctly.)

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
5. Does your child know the names of numbers? *(Mark "yes" if she identifies the three numbers below. Mark "sometimes" if she identifies two numbers.)* **3 1 2**	○	○	○	___
6. Does your child name at least four letters in her name? Point to the letters and ask, "What letter is this?" *(Point to the letters out of order.)*	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Can your child serve himself, taking food from one container to another, using utensils? For example, does your child use a large spoon to scoop applesauce from a jar into a bowl?	○	○	○	___
2. Does your child wash her hands and face using soap and water and dry off with a towel without help?	○	○	○	___
3. Does your child tell you at least four of the following? Please mark the items your child knows. ○ a. First name ○ b. Age ○ c. City he lives in ○ d. Last name ○ e. Boy or girl ○ f. Telephone number	○	○	○	___
4. Does your child dress and undress himself, including buttoning medium-size buttons and zipping front zippers?	○	○	○	___
5. Does your child use the toilet by herself? *(She goes to the bathroom, sits on the toilet, wipes, and flushes.)* Mark "yes" even if she does this after you remind her.	○	○	○	___
6. Does your child usually take turns and share with other children?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

SCORE AND TRANSFER TOTALS TO CHART BELOW: See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	33.19		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	31.28		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	26.54		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	29.99		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	39.07		●	●	●	●	●	●	●	●	○	○	○	○	○

Patient History Form - Newborn to 5 years

Patient Name_____ **DOB**_____

Sex M F History given by_____ **Date**_____

Patient Information:

Are immunizations up to date? Yes or No

Birth History: Was infant born early or late? Yes or No

If yes, how many weeks? _____

What was infants birth weight? _____

Did your child have any respiratory problems, jaundice, or other problems at birth?

_____

Acute Illness / Chronic Illness / Medical Issues: List all past and present diagnoses

_____

_____

Hospitalizations or ER Visits: List any that have occurred since the last well check

_____

_____

Surgeries: List any that have occurred since the last well check

_____

Allergies: _____

Medications: name, dose, what is it given for?

_____

_____

Social History:

Who does the patient live with?

_____

If biological parents are separated or don't live in the same home as the patient, how often does the child visit the other home?

_____

Does your child have any pets in or outside of the home? Yes No

If yes, list pets: _____

Does anyone in the household smoke or vape? _____

Any recent travel since the last well check? Yes No Where? _____

Family History - Please provide information for patient's parents, siblings and grandparents:

Heart Problems/ Heart Attack	Y	N	Migraines/Headaches	Y	N	Allergies	Y	N
High Cholesterol	Y	N	ADHD/ADD	Y	N	Eczema	Y	N
High Blood Pressure	Y	N	Diabetes	Y	N	Depression or Anxiety	Y	N
Asthma	Y	N	Thyroid Problems	Y	N	Obesity	Y	N
Stomach Problems	Y	N	Bleeding or Clotting Problems	Y	N	Alcoholism	Y	N
Kidney/Bladder Problems	Y	N	Anemia	Y	N	Drug Abuse	Y	N
Seizures	Y	N	Arthritis	Y	N	Cancer	Y	N

TEXAS Department of State Health Services

Lead Risk Questionnaire

Form Pb-110

Purpose: To identify children who need to be tested for lead exposure.

Instructions

- If **Yes or Don't Know**, test the child immediately.
- You may administer a blood lead test instead of using this questionnaire.
- For more information, contact the Texas Childhood Lead Poisoning Prevention Program at: 1-800-588-1248.

Patient's Name: _____ **DOB:** _____ **Medicaid #:** _____

Provider's Name: _____ **Administered by:** _____ **Date** _____

Questions

	Yes or Don't Know	No
1. Does your child live in or visit a home, day-care or other building built before 1978?	☐	☐
2. Does your child live in or visit a home, day-care or other building with ongoing repairs or remodeling?	☐	☐
3. Does your child eat or chew on non-food things like paint chips or dirt?	☐	☐
4. Does your child have a family member or friend who has or did have an elevated blood lead level?	☐	☐
5. Is your child a newly arrived refugee or foreign adoptee?	☐	☐
6. Does your child come in contact with an adult whose job or hobby involves lead exposure?	☐	☐

Examples

- House construction or repair
- Battery manufacturing or repair
- Burning lead-painted wood
- Automotive repair shop or junk yard
- Going to a firing range or reloading bullets
- Chemical preparation
- Valve and pipe fittings
- Brass/copper foundry
- Refinishing furniture
- Making fishing weights
- Radiator repair
- Pottery making
- Lead smelting
- Welding

7. Does your family use products from other countries such as pottery, health remedies, spices, or food?	☐	☐

Examples

- Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, and rueda
- Cosmetics such as kohl, surma, and sindor
- Imported or glazed pottery, imported candy, and imported nutritional pills other than vitamins.
- Foods canned or packaged outside the U.S.

Test Immediately

Fax this form to 512-776-7699 or mail to the address below.

Texas Childhood Lead Poisoning Prevention Program • Texas Department of State Health Services
PO BOX 149347 • Austin, TX 78714-9347 • 1-800-588-1248 • www.dshs.state.tx.us/lead

Revised December 22, 2011

PEDS RESPONSE FORM

Provider

Child's Name _____ *Parent's Name* _____

Child's Birthday _____ *Child's Age* _____ *Today's Date* _____

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child understands what you say?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child uses his or her hands and fingers to do things?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child uses his or her arms and legs?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child behaves?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child gets along with others?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child is learning to do things for himself/herself?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Do you have any concerns about how your child is learning preschool or school skills?
Circle one: *No* *Yes* *A little* *COMMENTS:*

Please list any other concerns.

#700PEDSv1-2009